

2025-2026 Seasonal Influenza (Flu) +/- COVID Vaccine Consent Form

Section 1: Patient Information

Last Name:	First Name:	Prov. Health Number:	Gender:	Age:
Phone Number:	Date of Birth (MM/DD/YYYY):	Emergency Contact Name and Phone Number:		
Address:		City:	Province:	Postal Code:

Section 2: Screening Questionnaire

In the past 10 days have you experienced any of the following: fever, new onset of cough or worsening of chronic cough, new or worsening shortness of breath or difficulty breathing, sore throat, runny nose, feeling unwell?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a reaction to any immunization previously (e.g. hives, fainting, difficulty breathing)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have allergies to medications, food (e.g. eggs), vaccine components or latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take any medications that suppress your immune system or are you immunocompromised?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take any medications (e.g. blood thinner) that can affect blood clotting or have a bleeding disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of Oculo-Respiratory Syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history Guillain-Barre Syndrome within 6 weeks of getting a flu shot?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant, nursing, or do you intend to become pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever suffered from inflammation of the heart or lining of the heart (myocarditis/pericarditis) after a previous dose of a COVID-19 vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a COVID-19 infection? If yes, please indicate when it was resolved:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you received a previous dose of COVID-19 vaccine? If yes, please specify: _____ Most recent dose date: _____	

Section 3: Consent Given By Patient/Agent

I, the undersigned patient, parent or guardian, have read or have had explained to me information about the vaccine. I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the Vaccine. After getting the Vaccine, I agree to wait in the clinic/pharmacy for 15 minutes (or the time recommended by the pharmacist).

I am aware it is possible (yet rare) to have an extreme allergic reaction to any component of the Vaccine. Serious reactions called "anaphylaxis" can be life-threatening medical emergencies. Symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. If I experience such symptoms following vaccination, I am aware it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to treat this reaction and 9-1-1 will be called to provide additional assistance. In the event of anaphylaxis, I, my agent, and/or EMS paramedics will receive a copy of this form. I understand the information contained on this form, may be disclosed to the public health authority and to other required parties for the purpose of adverse event and drug safety reporting.

I confirm that I want to receive the vaccine **OR** I confirm that I want my child to receive the vaccine

Patient/Agent Name (& Relationship)	Patient/Agent Signature	Date Signed (MM/DD/YYYY)
-------------------------------------	-------------------------	--------------------------

PHARMACY USE ONLY Section 4: Vaccine Documentation

<input type="checkbox"/> FLUZONE [®] 0.5mL IM pre-filled syringe DIN 2420643	<input type="checkbox"/> FLUAD Pediatric [®] 0.25mL IM pre-filled syringe DIN 02434881	<input type="checkbox"/> FLUAD [®] 0.5mL IM pre-filled syringe DIN 02362384	<input type="checkbox"/> FLUZONE High-Dose QUAD [®] 0.5mL IM PFS DIN 2445646	<input type="checkbox"/> FLUVIRAL [®] 0.5mL IM DIN 02420686	<input type="checkbox"/> COVID/ OTHER
<input type="checkbox"/> FLUZONE [®] 0.5mL IM 5mL multi-dose vial DIN 2365936	<input type="checkbox"/> FLULAVAL TETRA [®] 0.5mL IM multi-dose vial DIN 02420783	<input type="checkbox"/> FLUCELVAX [®] 0.5mL IM pre-filled syringe DIN 2553708	<input type="checkbox"/> FLUMIST [®] 0.1mL per nostril DIN 02426544	<input type="checkbox"/> INFLUVAC TETRA [®] 0.5mL IM pre-filled syringe DIN 02484854	Dose:
Vaccine #1	Lot #:	Expiry Date (MM/YYYY):	Site of Administration: <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Intranasal	Time of Immunization:	Date of Immunization (MM/DD/YYYY):
Vaccine #2	Lot #:	Expiry Date (MM/YYYY):	Site of Administration: <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Intranasal	Time of Immunization:	
Health Care Provider's Name and License Number:				Health Care Provider's Signature:	
NS Only	Patient condition before:	Response during:		Response immediately after:	